Beginning Billing Workshop Non-Emergency Transportation

Colorado Medicaid
2015

HCPF

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Training Objectives

- Billing Pre-Requisites
  - National Provider Identifier (NPI)
    - What it is and how to obtain one
  - Eligibility
    - How to verify
    - Know the different types

- Billing Basics
  - How to ensure your claims are timely
  - When to use the CMS 1500 paper claim form
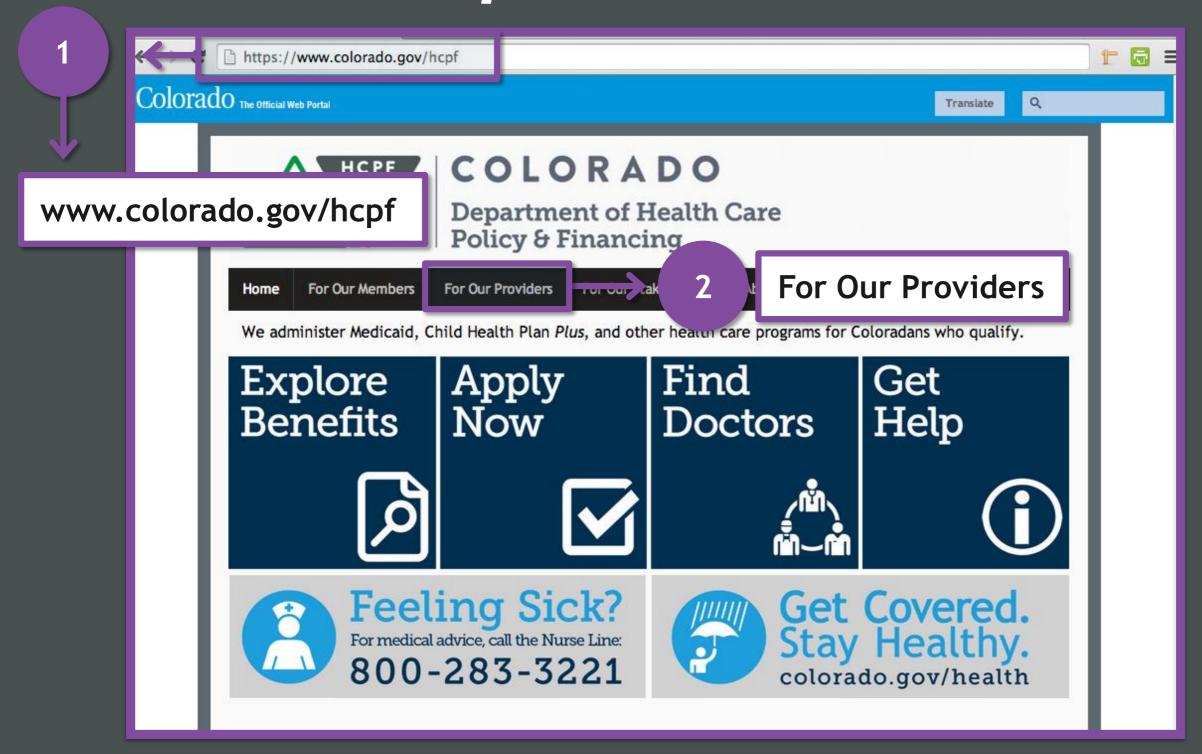 - How to bill when other payers are involved

What is an NPI?

- National Provider Identifier
- Unique 10-digit identification number issued to U.S. health care providers by CMS
- All HIPAA covered health care providers/organizations must use NPI in all billing transactions
- Are permanent once assigned
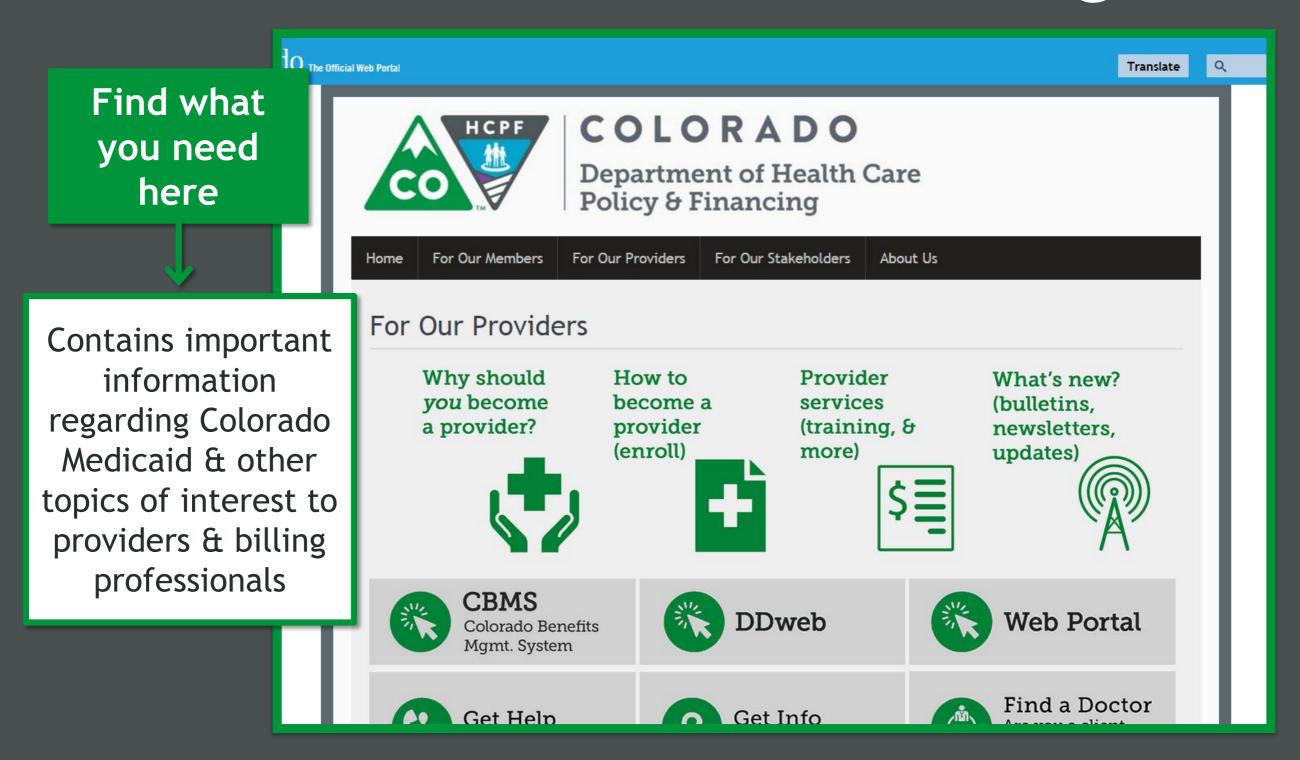 - ➢ Regardless of job/location changes

What is an NPI? (cont.)

- How to Obtain & Learn Additional Information:
  - CMS web page (paper copy)-
    - www.dms.hhs.gov/nationalproldentstand/
  - National Plan and Provider Enumeration System (NPPES)-
    - www.nppes.cms.hhs.gov
  - Enumerator-
    - 1-800-456-3203
    - 1-800-692-2326 TTY

NEW! Department Website

www.colorado.gov/hcpf

For Our Providers

NEW! Provider Home Page

Find what you need here

Contains important information regarding Colorado Medicaid & other topics of interest to providers & billing professionals

Provider Enrollment

Question:

What does **Provider** Enrollment do?

Answer:

Enrolls **providers** into the Colorado Medical Assistance Program, *not* members
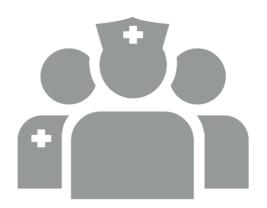
Question:

Who needs to enroll?

Answer:

Everyone who provides services for Medical Assistance Program members

Rendering Versus Billing

Rendering Provider

Individual that provides services to a Medicaid member

Billing Provider

Entity being reimbursed for service

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Verifying Eligibility

- Always print & save copy of eligibility verifications
- Keep eligibility information in member's file for auditing purposes
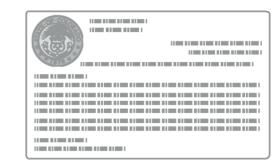- Ways to verify eligibility:

Colorado Medical Assistance Web Portal

Fax Back 1-800-493-0920

CMERS/AVRS 1-800-237-0757

Medicaid ID Card with Switch Vendor

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From the Noun Project:
"Internet" by OCHA Visual Information Unit
"Fax" by Vasily Ledovsky
"Telephone" by Edward Boatman

10

Eligibility Response Information

Eligibility Dates

Co-Pay Information

Third Party Liability (TPL)

Prepaid Health Plan

Medicare

Special Eligibility

BHO

Guarantee Number

Eligibility Request Response (271)

Eligibility Request

Provider ID: National Pro

From DOS: Through D

Client Detail

State ID: DOB:

Last Name: First Name

CO MEDICAL ASSISTANCE

Response Creation Date & Time: 05/19/2(

Contact Information for Questions on Res

Provider Relations Number: 800-237-075

Requesting Provider
Provider ID:
Name:

Client Details
Name:
State ID:

Return To Eligibility Inquiry

Client Eligibility Details

Eligibility Status: **Eligible**

Eligibility Benefit Date:
04/06/2011 - 04/06/2011

Guarantee Number: **111400000000**

Coverage Name: Medicaid

PREPAID HEALTH PLAN OR ACCOUNTABLE CARE COLLABORATIVE

Eligibility Benefit Date:
04/06/2011 - 04/06/2011

Messages:

MHPROV Services

Provider Name:

COLORADO HEALTH PARTNERSHIPS LLC

Provider Contact Phone Number:
800-804-5008

Information appears in sections:
- Requesting Provider, Member Details, Member Eligibility Details, etc.
- Use scroll bar on right to view details

Successful inquiry notes a Guarantee Number:
- Print copy of response for member's file when necessary

Reminder:
- Information received is based on what is available through the Colorado Benefits Management System (CBMS)
- Updates may take up to 72 hours

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Medicaid Identification Cards

- Both cards are valid
- Identification Card does not guarantee eligibility

Billing Overview

Record Retention

Claim submission

Prior Authorization Requests (PARs)

Timely filing

Extensions for timely filing

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Record Retention

- Providers must:
  - ➢ Maintain records for at least six (6) years
  - ➢ Longer if required by:
    - ▪ Regulation
    - ▪ Specific contract between provider & Colorado Medical Assistance Program
  - ➢ Furnish information upon request about payments claimed for Colorado Medical Assistance Program services

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Record Retention

- Medical records must:
  - ➢ Substantiate submitted claim information
  - ➢ Be signed & dated by person ordering & providing the service
    - ▪ Computerized signatures & dates may be used if electronic record keeping system meets Colorado Medical Assistance Program security requirements

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Submitting Claims

- Methods to submit:
  - ➢ Electronically through Web Portal
  - ➢ Electronically using Batch Vendor, Clearinghouse, or Billing Agent
  - ➢ Paper only when:
    - ▪ Pre-approved (consistently submits less than five (5) per month)
    - ▪ Claims require attachments

ICD-10 Implementation Delay

ICD-10 Implementation delayed until 10/1/2015

Claims with Dates of Service (DOS) **on** or **before** 9/30/15	**Use ICD-9 codes**
Claims with Dates of Service (DOS) **on** or **after** 10/1/2015	**Use ICD-10 codes**
Claims submitted with both ICD-9 and ICD-10 codes	**Will be rejected**

Providers Not Enrolled with EDI

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MEDICAL ASSISTANCE PROGRAM

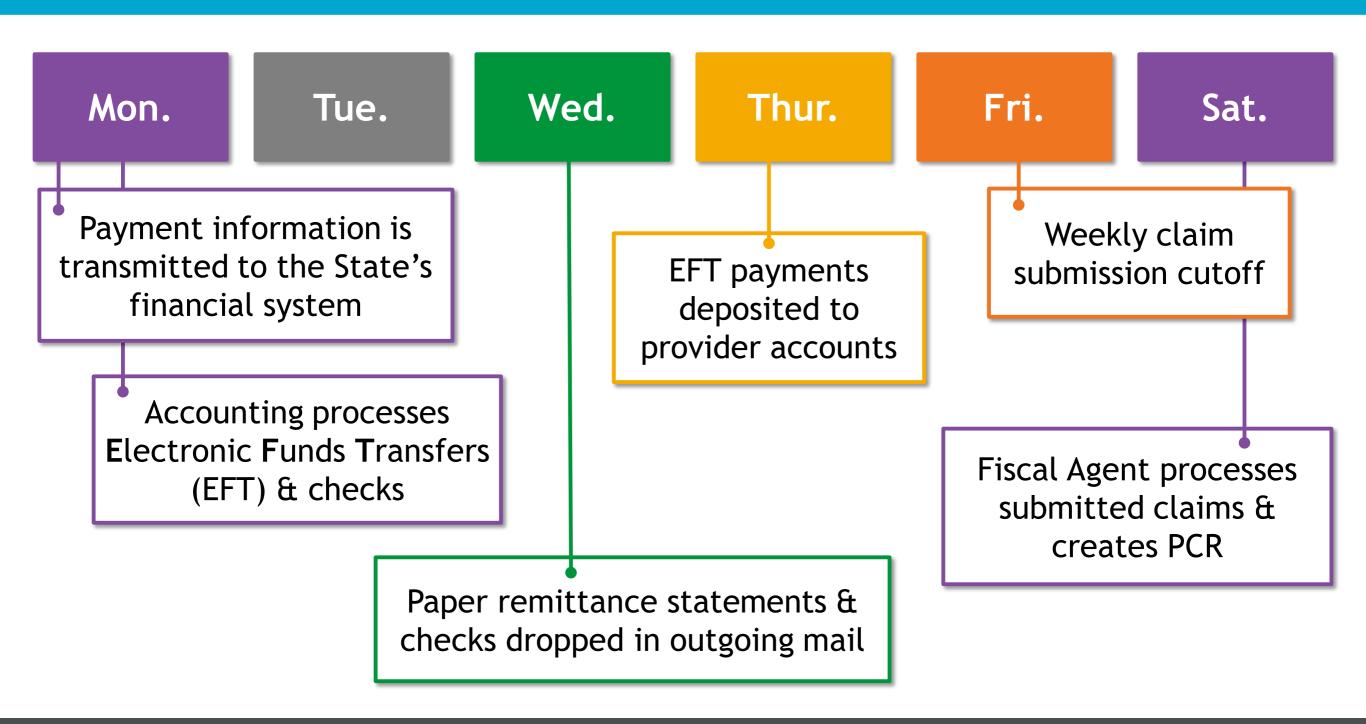*Provider EDI Enrollment Application*

Colorado Medical Assistance Program
PO Box 1100
Denver, Colorado 80201-1100
1-800-237-0757
colorado.gov/hcpf

Providers must be enrolled with EDI to:

- use the Web Portal
- submit HIPAA compliant claims
- make inquiries
- retrieve reports electronically
  - ➢ Select Provider Application for EDI Enrollment

Colorado.gov/hcpf/EDI-Support

Payment Processing Schedule

Mon.	Tue.	Wed.	Thur.	Fri.	Sat.

Payment information is transmitted to the State's financial system

Accounting processes Electronic Funds Transfers (EFT) & checks

EFT payments deposited to provider accounts

Weekly claim submission cutoff

Paper remittance statements & checks dropped in outgoing mail

Fiscal Agent processes submitted claims & creates PCR

Electronic Funds Transfer (EFT)

Advantages

- Free!
- No postal service delays
- Automatic deposits every Thursday
- Safest, fastest & easiest way to receive payments
- Colorado.gov/hcpf/provider-forms → Other Forms

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PARs Reviewed by ColoradoPAR

- With the **exception of Waiver and Nursing Facilities**:
  - ➢ The ColoradoPAR Program processes all PARs
    - ▪ including revisions
  - ➢ Visit ColoradoPAR.com for more information

Mail:	Phone:
Prior Authorization Request 55 N Robinson Ave., Suite 600 Oklahoma City, OK 73102	Phone: 1.888.454.7686 FAX: 1.866.492.3176 Web: ColoradoPAR.com

Electronic PAR Information

- PARs/revisions processed by the ColoradoPAR Program must be submitted via CareWebQI (CWQI)

- The ColoradoPAR Program will process PARs submitted by phone for:

  - ➢ emergent out-of-state

  - ➢ out-of area inpatient stays

  - ➢ e.g. where the patient is not in their home community and is seeking care with a specialist, and requires an authorization due to location constraints

PAR Letters/Inquiries

- Continue utilizing Web Portal for PAR letter retrieval/PAR status inquiries

- PAR number on PAR letter is only number accepted when submitting claims

- If a PAR Inquiry is performed and you cannot retrieve the information:

  - contact the ColoradoPAR Program

  - ensure you have the right PAR type

  - e.g. Medical PAR may have been requested but processed as a Supply PAR

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Transaction Control Number

Receipt Method
0 = Paper
2 = Medicare Crossover
3 = Electronic
4 = System Generated

Batch Number

Document Number

0 15 129 00 150 0 00037

Year of Receipt

Julian Date of Receipt

Adjustment Indicator
1 = Recovery
2 = Repayment

Timely Filing

- 120 days from Date of Service (DOS)
  - Determined by date of receipt, not postmark
  - PARs are not proof of timely filing
  - Certified mail is not proof of timely filing
  - Example – DOS January 1, 20XX:
    - Julian Date: 1
    - Add: 120
    - Julian Date = 121
    - Timely Filing = Day 121 (May 1st)

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Timely Filing

From "through" DOS

- Nursing Facility
- Home Health
- Waiver
- In- & Outpatient
- UB-04 Services

From delivery date

- Obstetrical Services
- Professional Fees
- Global Procedure Codes:
- Service Date = Delivery Date

From DOS

FQHC Separately Billed and additional Services

Documentation for Timely Filing

- 60 days from date on:
  - ➢ Provider Claim Report (PCR) Denial
  - ➢ Rejected or Returned Claim
  - ➢ Use delay reason codes on 837P transaction
  - ➢ Keep supporting documentation
- Paper Claims
  - ➢ CMS 1500- Note the Late Bill Override Date (LBOD) and the date of the last adverse action in field 19 (Additional Claim Information)

Timely Filing Extensions

- Extensions may be allowed when:
  - ➢ Commercial insurance has yet to pay/deny
  - ➢ Delayed member eligibility notification
    - ▪ Delayed Eligibility Notification Form
  - ➢ Backdated eligibility
    - ▪ Load letter from county

Timely Filing Extensions

Commercial Insurance

- 365 days from DOS

- 60 days from payment/denial date

- When nearing the 365 day cut-off:
  - File claim with Colorado Medicaid
    - Receive denial or rejection
  - Continue re-filing every 60 days until insurance information is available

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Timely Filing Extensions

Delayed Notification

- 60 days from eligibility notification date
  - Certification & Request for Timely Filing Extension – Delayed Eligibility Notification Form
    - Located in Forms section
    - Complete & retain for record of LBOD

- Bill electronically
  - If paper claim required, submit with copy of Delayed Eligibility Notification Form

- Steps you can take:
  - Review past records
  - Request billing information from member

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Timely Filing Extensions

Backdated Eligibility

- 120 days from date county enters eligibility into system
  - Report by obtaining State-authorized letter identifying:
    - County technician
    - Member name
    - Delayed or backdated
    - Date eligibility was updated

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CMS 1500

Who completes the CMS 1500?

HCBS/Waiver providers	Vision providers	Physicians
Supply providers	Surgeons	Transportation providers

CMS 1500

Emergency Transportation

- Emergency services require a physician's statement of medical necessity or trip report
  - ➢ Subject to audit for six (6) years
- Emergency transportation includes:
  - ➢ Ambulance
  - ➢ Air Ambulance

What Defines an "Emergency"?

- Sudden, urgent, usually unexpected occurrence or occasion requiring immediate action such that of:
  - ➤ Active labor & delivery
  - ➤ Acute symptoms of sufficient severity & severe pain in which, the absence of immediate medical attention might result in:
    - ▪ Placing health in serious jeopardy
    - ▪ Serious impairment to bodily functions
    - ▪ Dysfunction of any bodily organ or part

Non-Emergency Medical Transportation (NEMT)

- Non-Emergency Medical Transportation
  - ➢ Defined as transportation to and/or from a medical treatment that is not emergent in nature
    - ▪ Non-Emergency care is scheduled
  - ➢ NEMT is only available when member has no other form of transportation

Non-Emergency Medical Transportation

Types of NEMT

Mobility Vehicle	Train	Car
Wheelchair Van	Personal Vehicle	Bus
Plane	Taxi	Non-Emergency Ambulance

Non-Emergency Medical Transportation (NEMT)

- The following are not benefits of the Colorado Medical Assistance Program:

  ➢ Waiting time

  ➢ Charges when member is not in vehicle

  ➢ Transportation when not medically necessary

Colorado Rural Counties

- Alamosa
- Archuleta
- Chaffee
- Conejos
- Crowley
- Delta
- Eagle
- Fremont

- Garfield
- Grand
- Lake
- La Plata
- Logan
- Montezuma
- Montrose
- Morgan

- Otero
- Ouray
- Phillips
- Pitkin
- Prowers
- Rio Grande
- Routt
- Summit

NEMT

NEMT is administered in each member's respective county, except for members residing within the front range area

Transportation Broker

- Transportation providers serving the nine (9) front range counties can no longer directly bill the Colorado Medical Assistance Program for NEMT
- All NEMT services for the nine front-range counties must be:
  - ➢ Authorized
  - ➢ Approved
  - ➢ Arranged &
  - ➢ Paid, through Total Transit

Note:
Total Transit is the only NEMT broker contracted with Medicaid

Transportation Broker

- Total Transit manages Non-Emergency Medical Transportation (NEMT) program for providers whose members reside within the following nine (9) front range counties:

Adams	Arapahoe	Boulder
Broomfield	Denver	Douglas
Jefferson	Larimer	Weld

Transportation Broker

If you are a transportation provider wanting to provide NEMT services

or

Have a member in need of transportation within the nine (9) counties listed, please contact:

Total Transit

1-855-264-6368

Or visit their website at: www.tticolorado.com

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NEMT

- Members in the following programs do not qualify for non-emergency transportation benefits:
  - ➢ CHP+
  - ➢ OAP-state only (Old Age Pension)
  - ➢ Qualified Medicare Beneficiary-only (QMB-only)
  - ➢ QI-1 (Qualified Individuals-1)
  - ➢ SLMB (Specified Low Income Medicare Beneficiaries)

County Responsibilities

- As the State Designated Entity (SDE), the Department of Human/Social Services (DHS) in each county is responsible for:
  - ➢ approving services
  - ➢ arranging NEMT for Medicaid members

- The SDE is required to query members requesting NEMT:
  - ➢ To determine that the member is being transported to a Medicaid covered service
  - ➢ To ensure that the member has exhausted all means of accessing free transportation

County Responsibilities

- SDEs are required to inform members in writing of any requested transportation service that is being denied

- Denial letter must include:

  - reason for denial

  - "Member Appeal Right" language & instructions

    - same language that is included on the back of all formal claim denials sent from the Department's Fiscal Agent

County Responsibilities

- Although SDEs may be notified of changes or updates to programs, appeals and rules, rates, etc., the SDE is responsible for staying informed

- For updates and changes, refer to:
  - Provider Bulletins
  - Agency Letters
  - Web Portal messages

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Modes of Transportation

Mobility Vehicles

- Provided when:
  - Member has no transportation
  - The option is least costly
  - Most appropriate mode for member's condition
- May transport multiple parties at the same time
- Does not calculate charges based upon a meter
- May use wheelchair van billing codes only when:
  - Member is a physician-certified wheelchair user
  - Vehicle has appropriate wheelchair equipment

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Modes of Transportation

Wheelchair Van

- Only a benefit when:
  - ➢ Member is a physician-certified wheelchair user
  - ➢ Vehicle has been appropriately modified
- Oxygen administration is allowed
  - ➢ When medically necessary
- Unlike mobility vehicles, wheelchair van service is not regulated by Public Utilities Commission (PUC)
- May use mobility vehicle billing codes only when:
  - ➢ Member isn't a physician-certified wheelchair user

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Modes of Transportation

Bus or Train

- Benefits are provided when:
  - Member is traveling a great distance
  - It is the least costly means of transportation
  - Member's health condition is poor
  - Appropriate for in-state and out-of-state travel
  - No PAR required
  - For train, use procedure code A0110

Modes of Transportation

Air

- Services are provided when:
  - ➢ Transportation is required to support a medically necessary procedure that cannot be provided in Colorado

Non-Emergency Air Transportation

- NEMT benefits are provided when:
  - ➢ Point of pickup is **inaccessible** by land vehicle
  - ➢ Point of pickup is **accessible** by a land vehicle **But** great distances prohibit transporting
  - ➢ Great distances prohibit transporting member to the nearest appropriate location and member needs immediate attention
  - ➢ Member is suffering from an illness that makes other forms of transportation inadvisable

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Mileage Reimbursement

- For mileage reimbursement, you must provide the SDE with:
  - ➢ Name & address of vehicle owner
  - ➢ Destination address
- Reimbursement Rules
  - ➢ SDEs should route trip using mapping or similar GPS program to determine mileage
  - ➢ Print map page for documentation
  - ➢ Trip must be most direct route to and/or from medical appointment with closest qualified provider
  - ➢ Service must be a benefit of the Colorado Medical Assistance Program

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Ancillary Services

- All ancillary services require prior authorization by The ColoradoPAR Program:

Meals and lodging	Escort
Only authorized if trip cannot be completed in one calendar day	May accompany at-risk adults or children

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Over-the-Cap Expenses

- Expenses exceeding maximum allowable cap
  - Mental health hold members only qualify if being transported to:
    - Fort Logan
    - State facility in Pueblo
  - PAR documentation must indicate that the requested mode is:
    - Most appropriate
    - Least costly method of transportation

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Over-the-Cap Expenses (cont.)

- PAR must include documentation that:
    - Indicates (in detail) the medical condition and extenuating circumstances to support approving an over-the-cap request
    - Care is not available in member's local community
    - Member is seeing closest, appropriate, Colorado Medical Assistance Program provider

Transportation Billing Instructions

- Use diagnosis code 780 for all NEMT claims
  - ➢ Regardless of diagnosis
- For Place of Service Code
  - ➢ Enter '41' for land transportation
  - ➢ Enter '42' for air transportation
- Span dating is not allowed
- Claims that require attachments must be billed on paper

Benefit and Billing Information

For detailed benefit and billing information refer to:

www.colorado.gov/hcpf/ProviderServices

Billing Manuals → Transportation

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Common Denial Reasons

Timely Filing	Claim was submitted more than 120 days without a LBOD
Duplicate Claim	A subsequent claim was submitted after a claim for the same service has already been paid

Common Denial Reasons
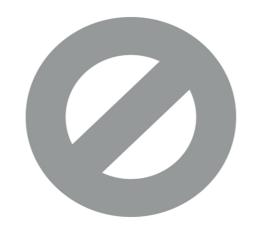
PAR not on file	No approved authorization on file for services that are being submitted
Total Charges invalid	Line item charges do not match the claim total

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Claims Process - Common Terms

Reject

Claim has primary data edits – **not** accepted by claims processing system

Denied

Claim processed & denied by claims processing system

Accept

Claim accepted by claims processing system

Paid

Claim processed & paid by claims processing system
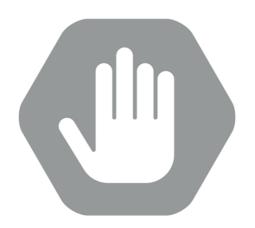
Claims Process - Common Terms

Adjustment

Correcting under/overpayments, claims paid at zero & claims history info

Rebill

Re-bill previously denied claim

Suspend

Claim must be manually reviewed before adjudication

Void

"Cancelling" a "paid" claim (wait 48 hours to rebill)

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Adjusting Claims

- What is an adjustment?
  - Adjustments create a replacement claim
  - Two step process: Credit & Repayment

Adjust a claim when	Do not adjust when
• Provider billed incorrect services or charges • Claim paid incorrectly	• Claim was denied • Claim is in process • Claim is suspended

Adjustment Methods

Web Portal

- Preferred method
- Easier to submit & track

Paper

- Complete field 22 on the CMS 1500 claim form

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Provider Claim Reports (PCRs)

- Contains the following claims information:
  - Paid
  - Denied
  - Adjusted
  - Voided
  - In process
- Providers required to retrieve PCR through File & Report Service (FRS)
  - Via Web Portal

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Provider Claim Reports (PCRs)

- Available through FRS for 60 days
- Two options to obtain duplicate PCRs:
  - Fiscal agent will send encrypted email with copy of PCR attached
    - $2.00/ page
  - Fiscal agent will mail copy of PCR via FedEx
    - Flat rate- $2.61/ page for business address
    - $2.86/ page for residential address
- Charge is assessed regardless of whether request made within 1 month of PCR issue date or not

Provider Claim Reports (PCRs)

Paid

```
                              * C L A I M S   P A I D *
                              ****************************

INVOICE  ------------ CLIENT ------------        TRANSACTION   DATES OF SVC    TOTAL    ALLOWED  COPAY  AMT OTH   CLM PMT
  NUM    -------    NAME -------  STATE ID  CONTROL NUMBER  FROM  TO    CHARGES   CHARGES  PAID  SOURCES    AMOUNT
  7015            CLIENT, IMA     Z000000  04080000000000001 040508 040508   132.00      69.46   2.00   0.00       69.46
PROC CODE - MODIFIER 99214 -                                 040508 040508   132.00      69.46   2.00
      TOTALS - THIS PROVIDER / THIS CATEGORY OF SERVICE .... TOTAL CLAIMS PAID   1      TOTAL PAYMENTS       69.46
```

Denied

```
                              * C L A I M S   D E N I E D *
                              ********************************

INVOICE   ------------   CLIENT   -------------------   TRANSACTION    DATES OF SERVICE    TOTAL  ----- DENIAL REASONS ----
  NUM     -----------   NAME   ---------  STATE ID  CONTROL NUMBER   FROM    TO     DENIED ------ ERROR CODES -----
STEDOTCCIOT           CLIENT, IMA       A000000   3080000000000003  03/05/08 03/06/08  245.04        1348
        TOTAL CLAIMS DENIED - THIS PROVIDER / THIS CATEGORY OF SERVICE    1
```

THE FOLLOWING IS A DESCRIPTION OF THE DENIAL REASON (EXC) CODES THAT APPEAR ABOVE:

1348   The billing provider specified is not a fully active provider because they are enrolled in an active/non-billable status of '62', '63', '64', or '65 for the FDOS on the claim. These active/non-billable providers can't receive payment directly. The provider must be in a fully active enrollment status of '60' or '61'.

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Provider Claim Reports (PCRs)

Adjustments

Recovery

```
                              ***********************************
                              *  A D J U S T M E N T S   P A I D *
                              ***********************************

INVOICE  ---  CLIENT    ----------   TRANSACTION   DATES OF SVC ADJ  TOTAL   ALLOWED  COPAY  AMT OTH  CLM PMT
  NUM   ------ NAME ------  STATE ID  CONTROL NUMBER  FROM  TO  RSN  CHARGES  CHARGES  PAID   SOURCES  AMOUNT
Z71      CLIENT, IMA    A000000   4080000000100002 041008 041808 406  92.82-   92.82-   0.00    0.00    92.82-
PROC CODE - MOD  T1019 - U1              041008 091808      92.82   92.82-
Z71      CLIENT, IMA    A000000   4080000000200002 041008 041808 406  114.24   114.24   0.00    0.00    114.24
PROC CODE - MOD  T1019 - U1              041008 041808      114.24   114.24
                                                    NET IMPACT    21.42
```

Repayment

Net Impact

Voids

```
                              ***********************************
                              *  A D J U S T M E N T S   P A I D *
                              ***********************************

INVOICE – CLIENT   --------------------   TRANSACTION  DATES OF SVC ADJ   TOTAL   ALLOWED COPAY  AMT OTH  CLM PMT
NUM  ------  NAME ------- STATE ID  CONTROL NUMBER  FROM  TO   RSN  CHARGES  CHARGES  PAID   SOURCES  AMOUNT
A83        CLIENT, IMA   Y000002   4080000000100009 040608 042008 212  642.60-   642.60-  0.00    0.00    642.60-
PROC CODE - MOD   T1019 - U1              040608 042008      642.60-   642.60-
                                                    NET IMPACT  642.60-
```

Provider Services

Xerox
1-800-237-0757

- Claims/Billing/Payment
- Forms/Website
- EDI
- Enrolling New Providers
- Updating existing provider profile

CGI
1-888-538-4275

- Email helpdesk.HCG.central.us@cgi.com
- CMAP Web Portal technical support
- CMAP Web Portal Password resets
- CMAP Web Portal End User training

Thank you!